

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12591

CERTIFICATE OF DEATH

Reg. Dist. No. 12580

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prinny Mch</u>				d. STREET ADDRESS <u>Prinny Mch</u>			
3. NAME OF DECEASED (Type or print) <u>Gilbert L. Ashley</u>				4. DATE OF DEATH <u>Nov. 13 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1893</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea Food Packing</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>crayfish</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Charles H. Ashley</u>				
14. MOTHER'S MAIDEN NAME <u>Agnes Lammie</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W. W. I.</u>				
16. SOCIAL SECURITY NO. <u>220-32-0493</u>			17. INFORMANT <u>Mrs. Bessie M. Ashley - Rock Hall - Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 17, 1958</u> to <u>Nov 13, 1958</u> , that I last saw the deceased alive on <u>Nov 7, 1958</u> and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William M. Patterson</u> M.D.				ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u>			
DATE SIGNED <u>11/14/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 16 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashley Burying Ground</u>		22d. LOCATION (City, town, or county) (State) <u>Prinny Mch - Rock Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion L. Williams - Chestertn Md</u>				24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12581

CERTIFICATE OF DEATH

12581

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Chestertown				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 72 Kent and Queen Anns Hospital				d. STREET ADDRESS High Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Biddle				4. DATE OF DEATH Month Day Year November 13, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1876	
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Drug store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Biddle				14. MOTHER'S MAIDEN NAME Sallie Usilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Address Hospital records, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 8 hours 2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anaemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-13 , 19 58 , to 11-13 , 19 58 , that I last saw the deceased alive on 11-13 , 19 58 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 11-13-58							
ACTUAL SIGNATURE A.C. Dick M.D.							
PHYSICIAN'S NAME (Type) A.C. Dick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR DATE NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Housh	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED		15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED		19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED		31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED		43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED		55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED		67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED		79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED		91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12592

CERTIFICATE OF DEATH

Reg. Dist. No.

12582

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton R. F. D.</u> c. LENGTH OF STAY IN 1b <u>1 Month</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u> d. STREET ADDRESS <u>3531 Hayward Ave.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Josephine Bohannon</u>				4. DATE OF DEATH Month Day Year <u>November 7 19 58</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 14, 1878</u>		9. AGE (In years last birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James A. Smith</u>						14. MOTHER'S MAIDEN NAME <u>Lydia Dwyer</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-36-9307</u>				17. INFORMANT Address <u>Mrs. John Mooney Worton, R. D. Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Asystole</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Cardio Vascular Disease</u> many years DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>one minute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Dilatation Congested failure</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>9/23</u> , 19 <u>58</u> to <u>11/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>58</u> , and that death occurred at <u>12:30 M.</u> from the causes and on the date stated above. P.M. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/8/58</u> ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u> <u>Chestertown, Md.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Centy</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>						ADDRESS <u>Still Pond, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar's name and address. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12593

CERTIFICATE OF DEATH

12583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Chestertown</u>		c. LENGTH OF STAY IN 1b <u>adult life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X(RFD Georgetown) Chestertown</u>		d. STREET ADDRESS <u>1 (Georgetown RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Briscoe</u>		4. DATE OF DEATH Month Day Year <u>Nov. 7, 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4, 1887</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Farm & Other</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sylvester Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Cecila unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Grace Briscoe</u>		Address <u>RFD Georgetown Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO <u>Hypertension</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 27</u> , 19 <u>58</u> , to <u>Nov 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 6</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> a. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norbert C. Nitsch</u>		ADDRESS (Street, city or town, State) <u>Rock Hall, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Norbert C. Nitsch</u>		DATE SIGNED <u>Nov 12 '58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>RFD Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

12584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Priny Wick</u>		d. STREET-ADDRESS <u>Priny Wick</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>A.</u> Last <u>Byden</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1915</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oystering</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>S. Arnold Byden</u>		14. MOTHER'S MAIDEN NAME <u>Jennie W. Pearson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-0432</u>		17. INFORMANT <u>Mrs. Helen K. Byden - Rock Hall, Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>William M. Gatewood</u> M.D. ADDRESS (Street, city or town, state) <u>Rock Hall</u> DATE SIGNED <u>11/20/58</u> PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u>	
22d. LOCATION (City, town, or county)		(State)		22e. REC'D BY REGISTRAR DATE <u>NOV 25 '58</u>	
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Knorr</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams - Chestertown Ind.</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 12595 12585 12595 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) PARIS B. CARNEY				4. DATE OF DEATH Month November Day 30 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1907		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Carney				14. MOTHER'S MAIDEN NAME Susan Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 222-09-6506		17. INFORMANT Martha Dudley, Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Degeneration of the myocardium DUE TO (c) Degeneration of the heart						INTERVAL BETWEEN ONSET AND DEATH 15 min - 4-5 years 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 30 , 19 55 to May 16 , 19 58 , that I last saw the deceased alive on May 16 , 19 58 , and that death occurred at 9.45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE GEZA KORALEWSKI				M.D. MILLINGTON, MD 12.1.58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Millington Colored Cem.		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward H. Lewis				ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DEC 3 '58	
				24b. REGISTRAR'S SIGNATURE William S. Frank			

12582

CERTIFICATE OF DEATH

Reg. Dist. No.

12586

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Still Born Baby Robert W. Coleman</u>		4. DATE OF DEATH <u>Nov. 18</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>
11. BIRTHPLACE (State or foreign country) <u>Kent Hosp. Chestertown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert W. Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Spencer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hosp. Friends, Chestertown Md</u>	
17. INFORMANT <u>Hosp. Friends, Chestertown Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atalectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature birth</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>58</u> , to <u>Nov 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 18</u> , 19 <u>58</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>11/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Farr, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 18 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestertown</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion V. Williams - Chestertown Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 19 58</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline S. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072192XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. RACE [Illegible]	
5. DATE OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. TIME OF DEATH [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. DISEASE OR INJURY [Illegible]		10. MEDICAL HISTORY [Illegible]	
11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF REGISTRAR [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF DECEASED [Illegible]	
15. SIGNATURE OF DECEASED [Illegible]		16. SIGNATURE OF DECEASED [Illegible]	
17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]	
21. SIGNATURE OF DECEASED [Illegible]		22. SIGNATURE OF DECEASED [Illegible]	
23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]	
27. SIGNATURE OF DECEASED [Illegible]		28. SIGNATURE OF DECEASED [Illegible]	
29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]	
33. SIGNATURE OF DECEASED [Illegible]		34. SIGNATURE OF DECEASED [Illegible]	
35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]	
39. SIGNATURE OF DECEASED [Illegible]		40. SIGNATURE OF DECEASED [Illegible]	
41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]	
45. SIGNATURE OF DECEASED [Illegible]		46. SIGNATURE OF DECEASED [Illegible]	
47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF DECEASED [Illegible]	
51. SIGNATURE OF DECEASED [Illegible]		52. SIGNATURE OF DECEASED [Illegible]	
53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]	
57. SIGNATURE OF DECEASED [Illegible]		58. SIGNATURE OF DECEASED [Illegible]	
59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF DECEASED [Illegible]	
63. SIGNATURE OF DECEASED [Illegible]		64. SIGNATURE OF DECEASED [Illegible]	
65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]	
69. SIGNATURE OF DECEASED [Illegible]		70. SIGNATURE OF DECEASED [Illegible]	
71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]	
75. SIGNATURE OF DECEASED [Illegible]		76. SIGNATURE OF DECEASED [Illegible]	
77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]	
81. SIGNATURE OF DECEASED [Illegible]		82. SIGNATURE OF DECEASED [Illegible]	
83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF DECEASED [Illegible]	
87. SIGNATURE OF DECEASED [Illegible]		88. SIGNATURE OF DECEASED [Illegible]	
89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]	
93. SIGNATURE OF DECEASED [Illegible]		94. SIGNATURE OF DECEASED [Illegible]	
95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]	
99. SIGNATURE OF DECEASED [Illegible]		100. SIGNATURE OF DECEASED [Illegible]	

12583

CERTIFICATE OF DEATH

12588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 CHESTERTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT & QUEEN ANNS HOSP.</u>				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAZEL BARBARA DULIN</u>				4. DATE OF DEATH Month Day Year <u>NOV 28 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-96</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELMER WALDON</u>				14. MOTHER'S MAIDEN NAME <u>Nora Buckley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-16-9305</u>		17. INFORMANT <u>C. K. Dulin</u> <u>RFD</u> <u>Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20</u> , 19 <u>56</u> , to <u>11-28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-28</u> , 19 <u>58</u> , and that death occurred at <u>1:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harry Paul Ross</u> M.D.							
PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS, M.D.</u>				<u>203 North Queen Street, Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 1, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jr. Order Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Preston, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Wills</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 58</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES J. JONES		M		35		1910		NEW YORK		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
JAN 15 1945		10:30 AM		HOSPITAL		HEART DISEASE		NATURAL		[Signature]		[Signature]		[Signature]	
17. FULL NAME OF PHYSICIAN		18. FULL NAME OF REGISTRAR		19. FULL NAME OF WITNESSES		20. FULL NAME OF WITNESSES		21. FULL NAME OF WITNESSES		22. FULL NAME OF WITNESSES		23. FULL NAME OF WITNESSES		24. FULL NAME OF WITNESSES	
DR. J. J. JONES		MR. J. J. JONES		MR. J. J. JONES		MR. J. J. JONES		MR. J. J. JONES		MR. J. J. JONES		MR. J. J. JONES		MR. J. J. JONES	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the registrar of vital statistics, or by a member of the family or other person who has been present at the death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12584 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12589

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u> <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesterton Md.</u>	c. LENGTH OF STAY IN 1b <u>12 x - 2</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent-McClellan</u>		d. STREET ADDRESS <u>R.D. #2</u>	
3. NAME OF DECEASED (Type or print) <u>Leslie Chester Jones</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11-1932</u>
9. AGE (In years last birthday) <u>26 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Explosive plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Whiteford Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Richard Jones</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Jones - ge - Aberdeen Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reserve explosion Bommer plant</u> <u>9193</u> DUE TO <u>McClellan Md</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Body badly burned - intestines protruding</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> a.m. <u>11/25</u> 19 <u>58</u> p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>	20f. (City or town) (County) (State) <u>McClellan - 2A MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <u>11/25/58</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 29, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>DELTA, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hawkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 28 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

IN THE STATE OF TEXAS, COUNTY OF DALLAS, I, J. H. [Name], Medical Examiner, do hereby certify that on the [Date] day of [Month], 19[Year], at [Location], the body of [Name] was found [Description of Findings].

1. Name of Deceased	2. Age	3. Sex	4. Race	5. Occupation
6. Date of Death	7. Time of Death	8. Place of Death	9. Cause of Death	10. Manner of Death
11. Description of Injuries or Condition				
12. Name and Address of Physician				
13. Name and Address of Coroner				
14. Name and Address of Medical Examiner				
15. Signature of Medical Examiner				
16. Signature of Coroner				
17. Signature of Physician				
18. Signature of Witness				
19. Signature of Witness				
20. Signature of Witness				
21. Signature of Witness				
22. Signature of Witness				
23. Signature of Witness				
24. Signature of Witness				
25. Signature of Witness				
26. Signature of Witness				
27. Signature of Witness				
28. Signature of Witness				
29. Signature of Witness				
30. Signature of Witness				
31. Signature of Witness				
32. Signature of Witness				
33. Signature of Witness				
34. Signature of Witness				
35. Signature of Witness				
36. Signature of Witness				
37. Signature of Witness				
38. Signature of Witness				
39. Signature of Witness				
40. Signature of Witness				
41. Signature of Witness				
42. Signature of Witness				
43. Signature of Witness				
44. Signature of Witness				
45. Signature of Witness				
46. Signature of Witness				
47. Signature of Witness				
48. Signature of Witness				
49. Signature of Witness				
50. Signature of Witness				
51. Signature of Witness				
52. Signature of Witness				
53. Signature of Witness				
54. Signature of Witness				
55. Signature of Witness				
56. Signature of Witness				
57. Signature of Witness				
58. Signature of Witness				
59. Signature of Witness				
60. Signature of Witness				
61. Signature of Witness				
62. Signature of Witness				
63. Signature of Witness				
64. Signature of Witness				
65. Signature of Witness				
66. Signature of Witness				
67. Signature of Witness				
68. Signature of Witness				
69. Signature of Witness				
70. Signature of Witness				
71. Signature of Witness				
72. Signature of Witness				
73. Signature of Witness				
74. Signature of Witness				
75. Signature of Witness				
76. Signature of Witness				
77. Signature of Witness				
78. Signature of Witness				
79. Signature of Witness				
80. Signature of Witness				
81. Signature of Witness				
82. Signature of Witness				
83. Signature of Witness				
84. Signature of Witness				
85. Signature of Witness				
86. Signature of Witness				
87. Signature of Witness				
88. Signature of Witness				
89. Signature of Witness				
90. Signature of Witness				
91. Signature of Witness				
92. Signature of Witness				
93. Signature of Witness				
94. Signature of Witness				
95. Signature of Witness				
96. Signature of Witness				
97. Signature of Witness				
98. Signature of Witness				
99. Signature of Witness				
100. Signature of Witness				

Witness my hand and seal this [Date] day of [Month], 19[Year].
J. H. [Name], Medical Examiner
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12585

CERTIFICATE OF DEATH

12590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Hospital		d. STREET ADDRESS 17X-2	
3. NAME OF DECEASED (Type or print) First WALTER Middle HIRAM Last JONES Sr.		4. DATE OF DEATH Month November Day 7 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 7, 1903
9. AGE (In years lost birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Paint	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Jones		14. MOTHER'S MAIDEN NAME Jennie M. Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-1902	
17. INFORMANT Mrs. Cora V. Jones, Sudlersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 WK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic Stenosis - Secondary to Rheumatic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/28/58 , 19 58 , to 11/7 , 19 58 , that I last saw the deceased alive on 11/6 , 19 58 , and that death occurred at 7 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Solon		ADDRESS (Street, city or town, state) Chestertown DATE SIGNED 11/8/58	
PHYSICIAN'S NAME (Type) Thomas J. Solon		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Millington Cem.		22d. LOCATION (City, town, or county) (State) Millington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellows, Millington Md.		24a. REC'D BY REGISTRAR NOV 12 58	
24b. REGISTRAR'S SIGNATURE Edward S. Haines			

CERTIFICATE OF DEATH

15-105

MD 100-10

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX M</p>		<p>3. AGE 35</p>	
<p>4. DATE OF DEATH APR 4 1968</p>		<p>5. TIME OF DEATH 10:00 PM</p>		<p>6. PLACE OF DEATH MEMPHIS, TENN</p>	
<p>7. CAUSE OF DEATH HEART DISEASE</p>		<p>8. MANNER OF DEATH ACCIDENT</p>		<p>9. PLACE OF BIRTH MOBILE, ALA</p>	
<p>10. OCCUPATION ATTORNEY</p>		<p>11. MARITAL STATUS SINGLE</p>		<p>12. EDUCATION COLLEGE</p>	
<p>13. PREVIOUS ILLNESS NONE</p>		<p>14. MEDICAL HISTORY NONE</p>		<p>15. SURVIVAL OF DECEASED YES</p>	
<p>16. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>17. SIGNATURE OF WITNESS JAMES EARL RAY</p>		<p>18. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>19. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>20. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>21. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>22. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>23. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>24. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>25. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>26. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>27. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>28. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>29. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>30. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>31. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>32. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>33. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>34. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>35. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>36. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>37. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>38. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>39. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>40. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>41. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>42. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>43. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>44. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>45. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>46. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>47. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>48. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>49. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>50. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>51. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>52. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>53. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>54. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>55. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>56. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>57. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>58. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>59. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>60. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>61. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>62. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>63. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>64. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>65. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>66. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>67. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>68. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>69. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>70. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>71. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>72. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>73. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>74. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>75. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>76. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>77. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>78. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>79. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>80. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>81. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>82. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>83. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>84. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>85. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>86. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>87. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>88. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>89. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>90. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>91. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>92. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>93. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>94. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>95. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>96. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>97. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>98. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>99. SIGNATURE OF DECEASED JAMES EARL RAY</p>	
<p>100. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>101. SIGNATURE OF DECEASED JAMES EARL RAY</p>		<p>102. SIGNATURE OF DECEASED JAMES EARL RAY</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH RECORD ACT, CHAPTER 10, SECTION 10-101, OF THE CODE OF MARYLAND, 1957, AS AMENDED.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12596

CERTIFICATE OF DEATH

Reg. Dist. No.

12591

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle M. Last KINCADE				4. DATE OF DEATH Month November Day 11 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April, 26, 1911	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 11 Days 15		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Greenbryer, West Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Fred L. Evans				14. MOTHER'S MAIDEN NAME Susie Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Cleanor Kincade, Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon and liver 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 year							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Millington, Md.				20g. (County) Kent		20h. (State) Md.	
21. I certify that I attended the deceased from Oct 7 , 19 58 , to Nov 11 , 19 58 , that I last saw the deceased alive on Nov 11 , 19 58 , and that death occurred at 4 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gaza Koralewski				ADDRESS (Street, city or town, state) MILLINGTON, MD			
PHYSICIAN'S NAME (Type) GAZA KORALEWSKI				DATE SIGNED 11. 12. 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Double Creek, Cem.		22d. LOCATION (City, town, or county) (State) Rural, Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Sellous, Millington, Md.				24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12586 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN lb adult life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chester River at foot of Cannon St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown d. STREET ADDRESS / Maple Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Alfred Minner First Middle Last		4. DATE OF DEATH Nov. 1 (First) 19 58 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1929 yrs. Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Garage	
11. BIRTHPLACE (State or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence B. Minner		14. MOTHER'S MAIDEN NAME Josephine Trembl Minner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW II & Korea		16. SOCIAL SECURITY NO. 218-24-5360	
17. INFORMANT C. B. Minner		Address Father Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 851x Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. Deceased was on board two freight boats loading grain. When the boats got ready to leave the pier he was missing. Police were notified. The body was found by dragging the pier next morning.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Wharf near Chestertown Kent Md		20c. TIME OF INJURY 1 Hour o. m. 11/1/58 Month Day Year	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/58	
22c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Cem.		22d. LOCATION (City, town, or county) Wilmington, Dela. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR NOV 5 '58	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

12500

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 25
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12500

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G236, 12/5/58 for

12587

CERTIFICATE OF DEATH

12593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Still Pond	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Ann's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle Davis Last Nevius		4. DATE OF DEATH Month November Day 24 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 75-80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Landscape	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Davis		14. MOTHER'S MAIDEN NAME Jane A. (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT JANE WHEELER		Address STILL POND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 10min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24/58 , 19 58 , to 11/24/58 , 19 58 , that I last saw the deceased alive on 11/24 , 19 58 , and that death occurred at 8:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 11/25/58			
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-28-58	22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMTY	22d. LOCATION (City, town, or county) (State) RED BANK N. J.
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS STILL POND, MD.	
24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE G. S. Hines	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12597

CERTIFICATE OF DEATH

12594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HYLAND First SEMANS Middle Last				4. DATE OF DEATH Month November Day 17 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September, 18, 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Del.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis E. Semans				14. MOTHER'S MAIDEN NAME Mary E. Warren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Lottie Semans,		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Coronary Artery Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus & Gangrene L foot							INTERVAL BETWEEN ONSET AND DEATH 13 years D.K. 2 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 11 , 19 58 , to Nov 16 , 19 58 , that I last saw the deceased alive on Nov 16 , 19 58 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. H. Hamilton				ADDRESS (Street, city or town, state) Millington Md.		DATE SIGNED 11/18/58	
PHYSICIAN'S NAME (Type) H. H. HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, 1958		22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellous				24a. REC'D BY REGISTRAR DATE NOV 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

12588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 97 CHESTERTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) KENT and Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First HAZEL Middle STEEVES Last Whitney		4. DATE OF DEATH		Month November Day 13 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1890	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY? Naturalize U.S.A.
13. FATHER'S NAME Clarence R. STEEVES			14. MOTHER'S MAIDEN NAME Lillie Mitten				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 033-18-2521		17. INFORMANT Address Hospital Records - Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Consecutive Heart Failure - Emphysema Fibrosis							INTERVAL BETWEEN ONSET AND DEATH 4 Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/18 , 19 58 , to 11/12 , 19 58 , that I last saw the deceased alive on 11/12 , 19 58 , and that death occurred at 12 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown DATE SIGNED m.d. ACTUAL SIGNATURE Thomas J. Solon M.D. Chestertown PHYSICIAN'S NAME (Type) Thomas J. Solon Nov. 13, 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Nov. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		22d. LOCATION (City, town, or county) (State) Wilmington, Dela.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE NOV 14 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. DISEASE		13. COMPLICATIONS		14. PREVIOUS ILLNESS		15. MEDICAL ATTENDANCE	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF CORONER		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF CLERK	

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN WHO ATTENDS THE DECEASED, OR BY THE CORONER IF THE DECEASED WAS NOT UNDER MEDICAL ATTENDANCE, OR BY THE REGISTRAR IF THE DECEASED WAS NOT UNDER MEDICAL ATTENDANCE AND THE CORONER WAS NOT AVAILABLE. THE CLERK SHALL SIGN THE CERTIFICATE AFTER IT HAS BEEN CHECKED BY HIMSELF.

12589

12589

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Fairlee) Chestertown				c. LENGTH OF STAY IN life 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Strong Nursing Home				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mattie Middle Rodgers Last Whittaker				4. DATE OF DEATH Month Nov. Day 10, Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1890	
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months 6 Days 7 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec. to Dean of College				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William A. Whittaker				14. MOTHER'S MAIDEN NAME Rodgers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218-30-0943			
17. INFORMANT Mrs. Geo. E. Hicks				Address Galena, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 Circulatory collapse DUE TO Degenerative cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Catalepsy						INTERVAL BETWEEN ONSET AND DEATH 45 minutes 6 months	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9-6 , 19 58 , to 11-10 , 19 58 , that I last saw the deceased alive on 10-15 , 19 58 , and that death occurred at 4:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 11/11/58							
ACTUAL SIGNATURE A. C. Dick				M.D. A. C. Dick			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Galena, Md. Kent Co.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR NOV 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WIA20 TO STACH20

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12590
CERTIFICATE OF DEATH

12597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) 105 Kent St.				e. STREET ADDRESS 105 Kent St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stella H. Williams				4. DATE OF DEATH Nov. 2, 1958			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Robert Houston				14. MOTHER'S MAIDEN NAME Cora Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 14-16-4496		17. INFORMANT Marion Miller - Chestertown, Md.			
		(If yes, give war or dates of service)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 181.0 DUE TO Carcinoma of bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 months	
						6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrolithiasis and renal failure							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/2 , 19 58 to Nov. 2 , 19 58 that I last saw the deceased alive on Nov. 2 , 19 58 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 11/4/58							
ACTUAL SIGNATURE Robert W. Farr M.D.							
PHYSICIAN'S NAME (Type) Robert W. Farr Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1958		22c. NAME OF CEMETERY OR CREMATORY Pomona Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR DATE NOV 6 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED
 NAME
 SEX
 AGE
 RACE
 BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 DATE OF DEATH
 TIME OF DEATH
 SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES
 SIGNATURE OF CLERK
 SIGNATURE OF MINISTER
 SIGNATURE OF JUDGE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----